LabLynx

2400 Lake Park Dr Suite 435 Phone: 123-456-7890
Smyrna, GA 30080 Fax: 123-456-7890

Payment Type	Priority
CLS	Normal
Collection Date	**CollectionTime**
11/01/2022	12:00AM

Order ID: 2211-00001

FOR OFFICE USE ONLY

LAV _____

Passport #:

ICD Codes:

Patient Information

Name: Test Patient
Address: 123 Main Street, Macon, GA 31210
Sex: Male | Race: Unknown | DOB: 03/03/1995 | Fasting: no
SSN: | Phone: | Room #:
Responsible Party (if different from patient):
Address:

Client Information

Location: Test Practice
Physician: Test Provider
Address: Test Address 1, Macon, GA 31210
Phone: | Fax:
Email: | NPI: 0123456789

Insurance Information

Primary: United Healthcare-A123456789

Secondary:

By signing this form, I am confirming that I have read and understood the "Financial Policy and Assignment of Health Plan Benefits and Rights" waiver and disclaimer presented on the second page of this form.

Patient Signature:

Panels / Profiles Ordered

Sample #: B22K0001
Sample Type: Whole blood
Container Type: LAV

Panel:
CBC w Diff

Physician Comments

Medications

Prescribed:

Admitted/Additional:

I hereby authorize the laboratory to perform the test(s) selected as indicated below. If no boxes are selected, I understand that the sample will be placed on hold. I understand and hereby acknowledge that I am ordering tests that I believe to be medically necessary for my patient and request the confirmatory and/or quantitative tests accordingly.

Physician: Test Provider | Date: 6/2/2023
Signature: On File